Department of HUMAN SERVICES

Integrated Health Home Workgroup Meeting April 13, 2022

April 13, 2022

Role Call

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person’s point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don’t just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

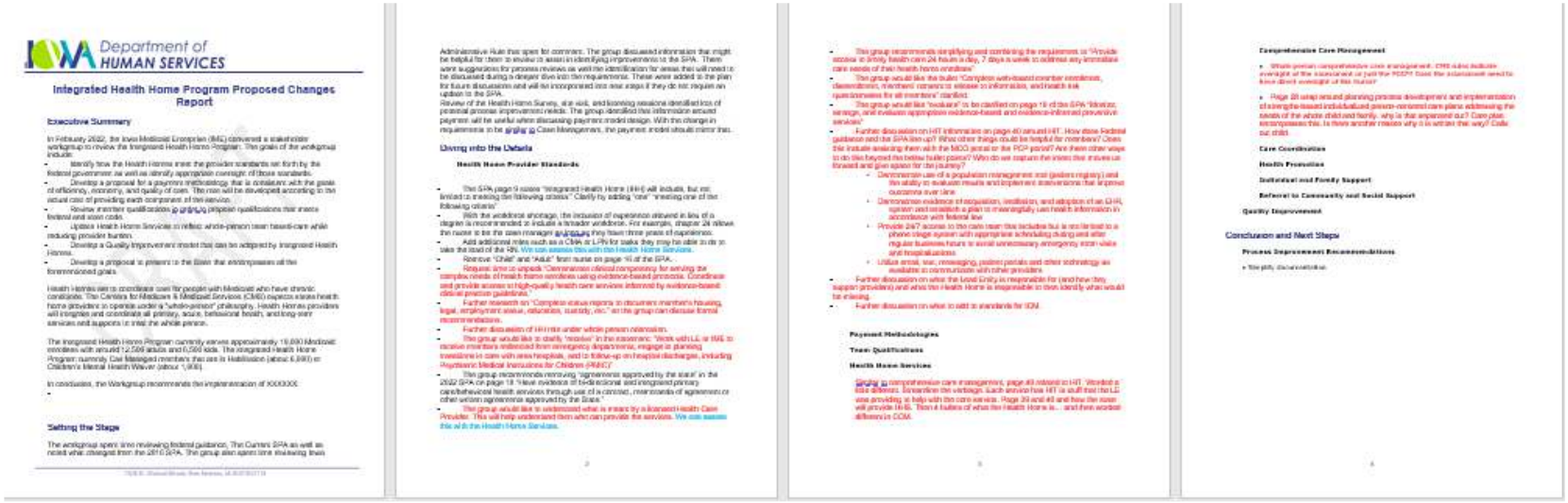
Objectives

- Review of Last Meeting
- Workgroup Report
- Continue Provider Standards Deep Dive
  - How does the Health Home Meet?
  - Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available.
  - Managing Habilitation and CMHW
  - How does the MCO/Iowa Medicaid support and oversee?
  - Address feedback of MCO/IME Administrative Oversight Burden
  - Using the larger organization to support the work
- Payment Methodologies
  - Health Home Services documentation on the claim.

Last Meeting

- Completed brainstorming activity questions 1-13 to assist in creating robust discussions.
- Questions/Answers

Workgroup Report



Department of HUMAN SERVICES

Integrated Health Home Program Proposed Changes Report

Executive Summary

In February 2022, the Iowa Medicaid Enterprise (IME) convened a stakeholder workgroup to review the Integrated Health Home Program. The goals of the workgroup include:

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as clinically appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The plan will be developed according to the actual cost of providing each component of the service.
- Review member qualifications [illegible] proposal qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the Board that encompasses all the recommended goals.

Health Homes aim to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects state health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to meet the whole person.

The Integrated Health Home Program currently serves approximately 19,000 Medicaid members with around 12,500 adults and 6,500 kids. The Integrated Health Home Program currently Dual Managed members that are in Habilitation (about 6,000) or Children's Mental Health Waiver (about 1,900).

In conclusion, the Workgroup recommends the implementation of XXXXXX.

Setting the Stage

The workgroup spent time reviewing federal guidance, The Current SPA as well as noted what changed from the 2016 SPA. The group also spent time reviewing their

Administrative Rule that open for comment. The group discussed information that might be helpful for them to review to assist in identifying improvements to the SPA. There were suggestions for process reviews as well the identification for areas that will need to be discussed during a deeper dive into the requirements. These were added to the plan for future discussions and will be incorporated into next steps if they do not require an update to the SPA.

Review of the Health Home Survey, site visit, and licensing sessions identified lots of potential process improvement needs. The group identified this information ensured payment will be useful when discussing payment model design. With this change in requirements to be [illegible] Case Managers, the payment model should mirror this.

Diving into the Details

Health Home Provider Standards

- The SPA page 9 states "Integrated Health Home (IHH) will include, but not limited to meeting the following criteria:" Clarify by adding "one" "meeting one of the following criteria"
- With the workforce shortage, the inclusion of experience obtained in lieu of a degree is recommended to include a broader workforce. For example, chapter 24 allows the nurse to be the case manager [illegible] they have three years of experience.
- Add additional roles such as a CMA or LPN for tasks they may be able to do to take the load of the RN. We can assess this with the Health Home Services.
- Remove "Child" and "Adult" from nurse on page 16 of the SPA.
- Request time to unpack "Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines."
- Further research on "Complex status reports to document member's housing, legal, employment, waiver, education, custody, etc." so the group can discuss formal recommendations.
- Further discussion of HH risk under whole person intersection.
- The group would like to clarify "receives" in the statements "Work with LE or RE to receive member referrals" and "Engage in planning transitions in care with area hospitals, and to follow-up on hospital discharges, including Psychiatric Medical Inpatients for Children (PMIC)"
- The group recommends removing "agreements approved by the state" in the 2022 SPA on page 18 "Have evidence of bi-directional and integrated primary care/behavioral health services through use of a common, mechanisms of agreement or other written agreements approved by the State."
- The group would like to understand what is meant by a licensed Health Care Provider. This will help understand then who can provide the services. We can assess this with the Health Home Services.

- The group recommends simplifying and combining the requirements in "Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees"
- The group would like the bullet "Complete early-based member enrollment, disenrollment, members' consent or release of information, and health risk questionnaires for all members" clarified.
- The group would like "evaluate" to be clarified on page 19 of the SPA "Monitor, manage, and evaluate appropriate evidence-based and evidence-informed preventive services."
- Further discussion on HIT information on page 40 around HIT. How does Federal guidance and the SPA line up? What other things could be helpful for members? Does this include assisting them with the MCO portal or the PCP portal? Are there other ways to do this beyond the below bullet points? Who do we capture the wishes that a loved us forward and give option for the journey?
  - Demonstrate use of a population management tool (patient registry) and the ability to evaluate results and implement interventions that improve outcomes over time
  - Demonstrate evidence of acquisition, installation, and adoption of an EHR system and establish a plan to meaningfully use health information in accordance with federal law
  - Provide 24/7 access to the care team this includes but is not limited to a phone triage system with appropriate scheduling during and after regular business hours to avoid unnecessary emergency room visits and hospitalizations
  - Utilize email, text, messaging, patient portals and other technology as available to communicate with other providers
- Further discussion on when the Lead Entity is responsible for (and how they support providers) and when the Health Home is responsible to then identify when would be missing.
- Further discussion on when to add or standards for IDN

Payment Methodologies

Team Qualifications

Health Home Services

[illegible] a comprehensive care management, page 40 related to HIT. Worded a little different. Remember the verbiage. Such and we how HIT is stuff that the LE was providing or help with the care service. Page 39 and 40 and how the nurse will provide HHS. Think it bullets of what the Health Home is… and think worded different in COM.

Comprehensive Care Management

- Whole-person comprehensive care management. CMS rules indicate oversight of the assessment or just the POCP? Does the assessor need to have direct oversight of this nurse?
- Page 38 setup area and planning process development and implementation of using the issued individualized person-centered care plans addressing the needs of the whole child and family, why is that empanneled out? Care plan encompasses this. Is there another reasons why it is written the way? Calls out child.

Care Coordination

Health Promotion

Individual and Family Support

Referral to Community and Social Support

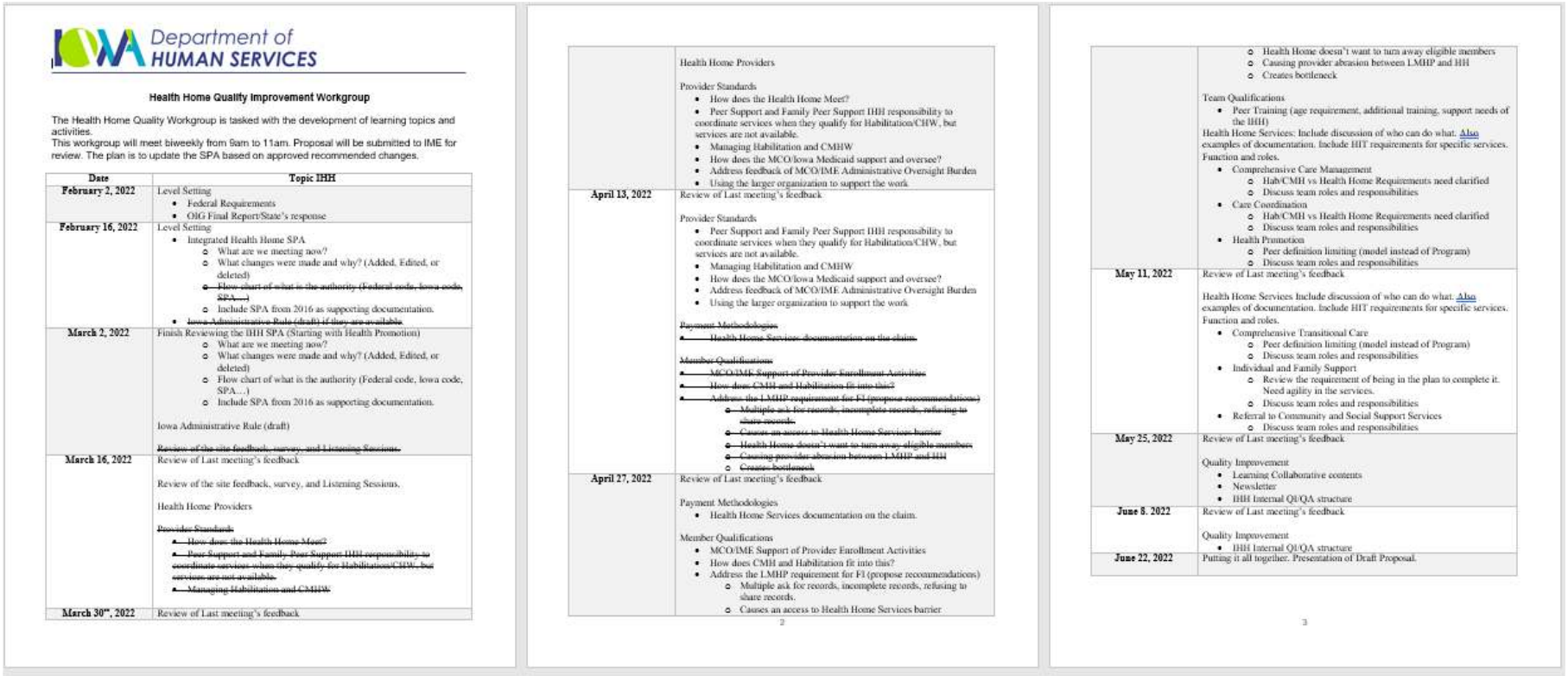
Quality Improvement

Conclusion and Next Steps

Process Improvement Recommendations

- Title shift, clinical certificate

Overview of the Timeline



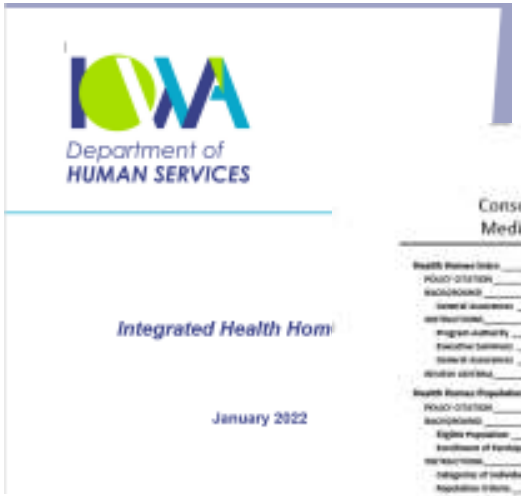
Department of HUMAN SERVICES

Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities.
This workgroup will meet biweekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

Date	Topic IHH
February 2, 2022	Level Setting • Federal Requirements • OIG Final Report/State's response
February 16, 2022	Level Setting • Integrated Health Home SPA ○ What are we meeting now? ○ What changes were made and why? (Added, Edited, or deleted) ○ ~~Flow chart of what is the authority (Federal code, Iowa code, SPA…)~~ ○ Include SPA from 2016 as supporting documentation. • ~~Iowa Administrative Rule (draft) if they are available.~~
March 2, 2022	Finish Reviewing the IHH SPA (Starting with Health Promotion) ○ What are we meeting now? ○ What changes were made and why? (Added, Edited, or deleted) ○ Flow chart of what is the authority (Federal code, Iowa code, SPA…) ○ Include SPA from 2016 as supporting documentation. Iowa Administrative Rule (draft) ~~Review of the site feedback, survey, and Listening Sessions.~~
March 16, 2022	Review of Last meeting's feedback Review of the site feedback, survey, and Listening Sessions. Health Home Providers ~~Provider Standards~~ ~~• How does the Health Home Meet?~~ ~~• Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available.~~ ~~• Managing Habilitation and CMHW~~
March 30th, 2022	Review of Last meeting's feedback
	Health Home Providers Provider Standards • How does the Health Home Meet? • Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available. • Managing Habilitation and CMHW • How does the MCO/Iowa Medicaid support and oversee? • Address feedback of MCO/IME Administrative Oversight Burden • Using the larger organization to support the work
April 13, 2022	Review of Last meeting's feedback Provider Standards • Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available. • Managing Habilitation and CMHW • How does the MCO/Iowa Medicaid support and oversee? • Address feedback of MCO/IME Administrative Oversight Burden • Using the larger organization to support the work ~~Payment Methodologies~~ ~~• Health Home Services documentation on the claim.~~ ~~Member Qualifications~~ ~~• MCO/IME Support of Provider Enrollment Activities~~ ~~• How does CMH and Habilitation fit into this?~~ ~~• Address the LMHP requirement for FI (propose recommendations)~~ ~~○ Multiple ask for records, incomplete records, refusing to share records.~~ ~~○ Causes an access to Health Home Services barrier~~ ~~○ Health Home doesn't want to turn away eligible members~~ ~~○ Causing provider abrasion between LMHP and HH~~ ~~○ Creates bottleneck~~
April 27, 2022	Review of Last meeting's feedback Payment Methodologies • Health Home Services documentation on the claim. Member Qualifications • MCO/IME Support of Provider Enrollment Activities • How does CMH and Habilitation fit into this? • Address the LMHP requirement for FI (propose recommendations) ○ Multiple ask for records, incomplete records, refusing to share records. ○ Causes an access to Health Home Services barrier
	○ Health Home doesn't want to turn away eligible members ○ Causing provider abrasion between LMHP and HH ○ Creates bottleneck Team Qualifications • Peer Training (age requirement, additional training, support needs of the IHH) Health Home Services: Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Care Management ○ Hab/CMH vs Health Home Requirements need clarified ○ Discuss team roles and responsibilities • Care Coordination ○ Hab/CMH vs Health Home Requirements need clarified ○ Discuss team roles and responsibilities • Health Promotion ○ Peer definition limiting (model instead of Program) ○ Discuss team roles and responsibilities
May 11, 2022	Review of Last meeting's feedback Health Home Services Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles. • Comprehensive Transitional Care ○ Peer definition limiting (model instead of Program) ○ Discuss team roles and responsibilities • Individual and Family Support ○ Review the requirement of being in the plan to complete it. Need agility in the services. ○ Discuss team roles and responsibilities • Referral to Community and Social Support Services ○ Discuss team roles and responsibilities
May 25, 2022	Review of Last meeting's feedback Quality Improvement • Learning Collaborative contents • Newsletter • IHH Internal QI/QA structure
June 8, 2022	Review of Last meeting's feedback Quality Improvement • IHH Internal QI/QA structure
June 22, 2022	Putting it all together. Presentation of Draft Proposal.

Documents for Today



11 Health Home Core Functions

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Delivery System Principles

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols.
- Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.
- Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.
- Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.
- Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.
- Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.).
- Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings.
- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.

Provider Standards

Consider Moving this to Health Home Services

Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available.

Lead Entity Standards Review

Lead Entity Roles

- Psychiatrist
- Physician
- Nurse Care Manager
- Care Coordinators

Evaluate and Select IHH Providers

- Identification of providers who meet the standards of participation to form an Integrated Health Home
- Assessment of the Integrated Health Home and medical health provider's capacity to coordinate integrated care
- Educate and support providers to coordinate integrated care
- Provide oversight, training, and technical support for Integrated Health Home providers to coordinate integrated care
- Provide infrastructure and tools to Integrated Health Home providers and primary care physical providers for coordination

Lead Entity Tools

- Repository for claims to allow the IHH to identify at the individual member level.
  - Pharmacy
  - ED/Hospitalizations
  - Any provider visit
  - Lab results
  - Authorizations
  - Case management information (PH/BH or CBCM)
  - Assessment results (Health Risk Assessment)
  - PCP
- Enrollment Report
  - Risk Score
  - In a Waiver other than Hab/CMH
  - Medicaid active Y/N
  - Medicaid renewal date
  - PCP
  - ITC PCSP/LOC
- Gap in Care Reports
  - ED/Hospitalizations
  - MCO daily inpatient report
  - Preventative care gaps
- Scorecard related to P4P Measures
- Amerigroup Service Tracking (Hab/ CMHW) report

Provide Clinical and Care Coordination Support to Integrated Health Home providers

- Confirmation of screening and identification of members eligible for Integrated Health Home Services
- Provide oversight and support of Integrated Health Home providers to develop care plans and identify care management interventions for Integrated Health Home enrollees
- Providing or contracting for care coordination, including face-to-face meetings, as necessary to ensure implementation of care plan and appropriate receipt of services
- Gathering and sharing member-level information regarding health care utilization, gaps in care, and medications
- Monitor and intervene for Integrated Health Home members who are high need with complex treatment plans
- Facilitate shared treatment planning meetings for members with complex situations

Develop Provider Information Technology Infrastructure and Provide Program Tools.

- Providing tools for Integrated Health Home providers to assess and customize care management based on the physical/behavioral health risk level of recipient
- Performing data analytics on personal, medical and pharmacy data to identify patterns of care, as well as track, and close gaps in care
- Providing outcomes tools and measurement protocols to assess Integrated Health Home concept effectiveness
- Providing clinical guidelines and other decision support tools
- Repository for member data including claims, laboratory, and Continuing Care Document (CCD) data whenever possible
- Support providers to share data including CCD or other data from electronic health records (EHR)

Develop and Offer Learning Activities Which Will Support Providers of Integrated Health Home Services.

- Providing quality driven, cost effective, culturally appropriate, and person and family driven Health Home Services
- High quality health care services informed by evidence-based clinical practice guidelines
- Preventive and health promotion services, including prevention of mental illness and substance use disorders
- Comprehensive care management, care coordination, and transitional care across settings (transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care)
- Chronic disease management, including self-management support to members and their families
- Demonstrating a capacity to use health information technology to link services, facilitate communication among team members and between the Health Home Team and individual and family care givers, and provide feedback to practices, as feasible and appropriate
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

State Support

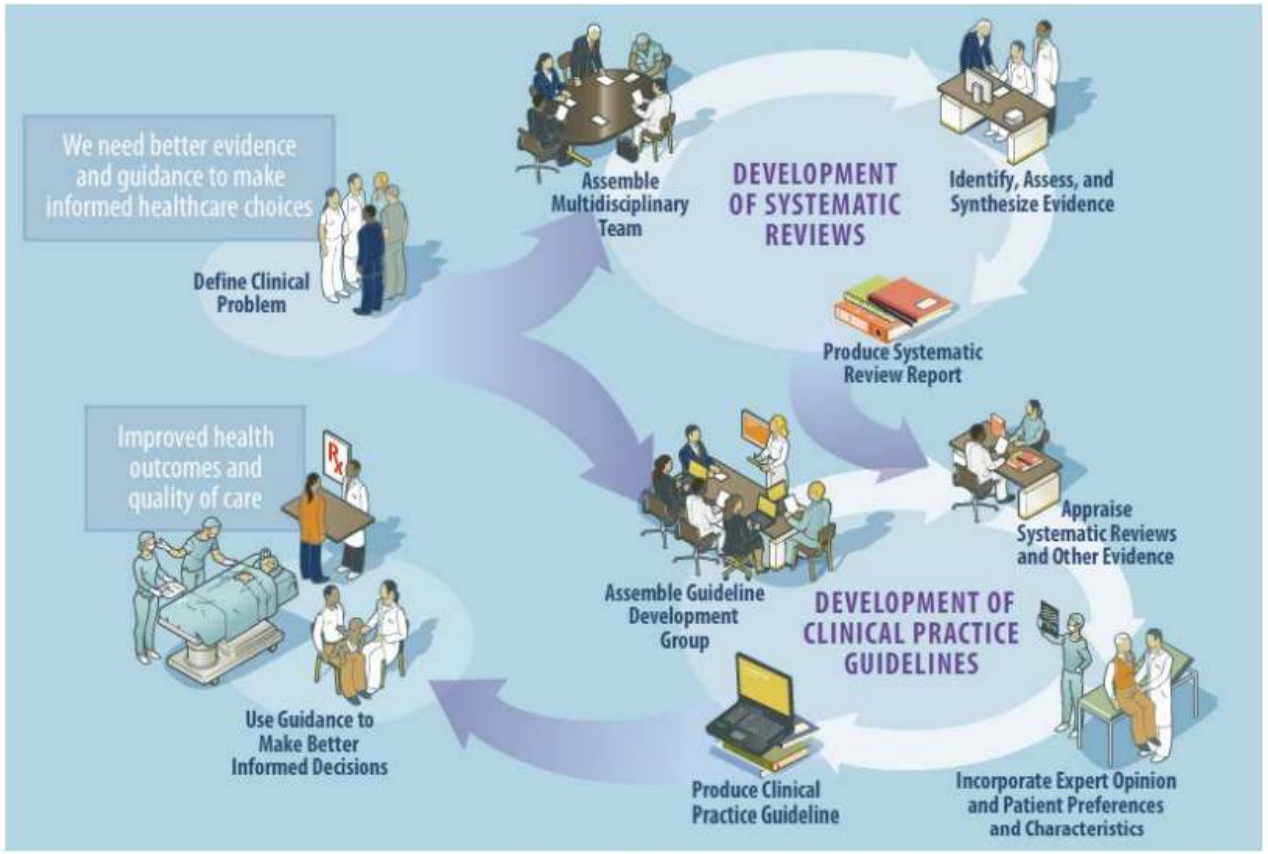
Describe the methods by which the state will support the Health Homes providers in addressing each of the eleven components of a Health Homes program identified by CMS as being critical in assuring timely, comprehensive and high-quality Health Homes services.

Provider Standards: Clinical Competency for Serving the Complex Needs using Evidenced-Based Protocols.

Demonstrate Clinical Competency for Serving the Complex Needs using Evidenced-Based Protocols.

Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.

Evidenced-Based



nationalacademies.org/hmd/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx

Example: Schizophrenia

Evidence-based treatments for schizophrenia include:

- Medication
- Social Skills Training
- Family-based services
- Supported Employment
- Cognitive Behavioral Therapy (CBT)
- Assertive Community Treatment (ACT)
- Illness Self-Management
- Psychosocial Interventions for Alcohol and Substance Use Disorders
- Psychosocial Interventions for Weight Management

Evidence-Based Treatment for Schizophrenia - Mind Matters Institute

Example: Diabetes

Table of Contents.

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“Whole-Person” Approach to Care Using a Comprehensive Needs Assessment and an Integrated Person-Centered Care Planning Process to Coordinate Care

Whole-Person Orientation

Care that is patient-centered and addresses the full range of a patient's medical and behavioral health needs, culture, values, and preferences. It helps patients become active participants in their own health care.

Integrated Behavioral Health & Primary Care: Terms To Know (ahrq.gov)

IHH Role with Whole Person Care

Health Homes must operate under a “whole-person” philosophy and be responsible for coordinating primary and acute care, behavioral health (mental health and substance use) and long-term services and supports; providing wellness support and transitional services; as well as linkages to community and social support services

Provide health home services that operate under a “whole-person” approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.

A person-centered care plan is developed for each individual in a way that coordinates and integrates all of an individual’s clinical and non-clinical health-care related needs and services.

Consistent with the “whole-person” philosophy that requires the Health Homes to have the systems and infrastructure in place for coordinating and integrating all primary, acute, behavioral health (mental health and substance use), long term services and community and social supports for the Health Homes enrollees

Complete status reports to document member's housing, legal, employment status, education, custody, etc."

- This information is important have this documentation for whole person care, and ideally shared through a CCD using HIT.

Health Home providers must agree to report on the health home quality measures as a condition of receiving payment for health home services. In addition, Health Homes must have mechanisms in place to share health information, link services, facilitate communication among the interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.

Continuous Quality Improvement Program

Continuous Quality Improvement

- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
  - Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- The Health Home must have a continuous QI program. What should the requirement look like in the SPA?

Discussion of “Evaluate”

- SPA 2022 Bottom of 18 “monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services. The word “evaluate” stood out and not sure what that means”
  - Do those services improve individual member’s outcomes?
  - Do those services improve your population outcomes?
  - Federal language states, “that permits an evaluation” Based on the discussion, what is the group’s recommendation?

Next Steps

- Review of this meeting's feedback
- Review Updated Workgroup Report
- Health Home Standards
  - HIT and Habilitation/CMH Waiver
- Payment Methodologies
  - Health Home Services documentation on the claim.
- Member Qualifications
  - MCO/IME Support of Provider Enrollment Activities
  - How does CMH and Habilitation fit into this?
  - Address the LMHP requirement for FI (propose recommendations)
    - Multiple ask for records, incomplete records, refusing to share records.
    - Causes an access to Health Home Services barrier
    - Health Home doesn't want to turn away eligible members
    - Causing provider abrasion between LMHP and HH
    - Creates bottleneck